



COMMUNITY
MENTAL HEALTH
AFFILIATES, INC.

March 21, 2005

Cristine A. Vogel, Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

2005 MAR 22 AM 10:43

RECEIVED

Dear Commissioner Vogel:

Enclosed please find an original and five copies of Community Mental Health Affiliates, Inc.'s "Letter of Intent" to transfer and relocate the Alliance Treatment Center into New Britain.

Please feel free to contact me at 826-1358 if you should have any questions regarding this matter.

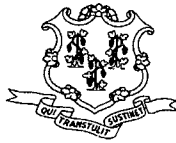
Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Muradian".

Mark Muradian, DPA
Executive Director





**State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030**

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Alliance Treatment Center	
Doing Business As	Community Mental Health Affiliates, Inc.	
Name of Parent Corporation	Central Connecticut Health Alliance	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	121 West Avon Road Avon, CT 06001	
Applicant type (e.g., profit/non-profit)	Non-Profit	
Contact person, including title or position	Mark Muradian Executive Director	
Contact person's street mailing address	29 Russell Street New Britain, CT 06052	
Contact person's phone #, fax # and e-mail address	P: 860-826-1358 F: 860-229-6575 mmuradian@cmhacc.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Alliance Treatment Center

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc)

☐ Replacement

☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc)

☒ Relocation

☐ Service Termination

☒ Bed Addition

☐ Bed Reduction

☒ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost cost greater than \$ 1,000,000

☐ Equipment Acquisition greater than \$ 400,000

☐ New

☐ Replacement

☐ Major Medical

☐ Imaging

☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$1,000,000

c. Location of proposal (Town including street address):

33 Highland Street, New Britain, CT 06052

d. List all the municipalities this project is intended to serve:

Berlin, Bristol, Burlington, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Southington, Terryville, Waterbury and Wethersfield

e. Estimated starting date for the project: November 1, 2005

- f. Type of project: 9, 18, 30, 31 (Fill in the appropriate number(s) from page 7 of this form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
Detoxification	15	15	1	16
Intensive Residential	15	15	3	18

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Capital Expenditure: \$1,300,000
- b. Please provide the following breakdown as appropriate:

Construction/Renovations	\$1,300,000
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	\$1,300,000
Fair Market Value of Leased Equipment	
Total Capital Cost	\$1,300,000

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

- ☐ Applicant's Equity
 ☐ Lease Financing
 ☐ Conventional Loan
☐ Charitable Contributions
 ☐ CHEFA Financing
 ☒ Grant Funding
☐ Funded Depreciation
 ☐ Other (specify):

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

SECTION IV. PROJECT DESCRIPTION

- 1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.***

Alliance Treatment Center currently is licensed by DPH as "Facility for the Care or Treatment of Substance Abusive or Dependent Persons" with the current configuration of services:

- 15 intensive residential beds
- 15 detoxification beds
- Residential detoxification and evaluation
- Intensive treatment
- Day and evening treatment
- Outpatient treatment
- Ambulatory chemical detoxification treatment

- 2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?***

The same licensing category will be sought and the same configuration of services will be provided.

- 3. Who is the current population served and who is the target population to be served?***

The primary target population that is served at Alliance Treatment Center are DMHAS clients under the SAGA behavioral health system. It also serves clients under the DSS Medicaid system. It is anticipated that the primary target population served will increase once the programs are relocated to New Britain.

- 4. Identify any unmet need and how this project will fulfill that need.***

Currently, the New Britain area has no residential services for women with substance abuse problems. This service will be able to provide this in New Britain. Additionally, there is no residential detoxification services located in the New Britain area. This project will meet those residential service needs.

- 5. Are there any similar existing service providers in the proposed geographic area?***

No. The closest services for New Britain/Bristol area clients would be in Middletown or Hartford. Neither of these locations are easily accessible.

6. *What is the effect of this project on the health care delivery system in the State of Connecticut?*

It will provide improved access for New Britain area residents, especially for those who are being transferred from the emergency department of New Britain General Hospital. Additionally, it will provide the primary local providers (Community Mental Health Affiliates, Inc. and New Britain General Hospital) of behavioral health services with rapid access to an intensive level of substance abuse services. Additionally, there will be an enhanced capability to continue dual diagnosis (co-occurring) services in the New Britain area. This has been identified as a significant need for Connecticut.

7. *Who will be responsible for providing the service?*

Community Mental Health Affiliates will be responsible for operating these services. CMHA is the local mental health authority for DMHAS and provides a wide array of behavioral health services in the local catchment area.

8. *Who are the payers of this service?*

- A. DMHAS/SAGA
- B. DSS/Medicaid
- C. Private party third party insurance
- D. Self-Pay

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0231

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Alliance Treatment Center, Inc. of Avon, CT, d/b/a Alliance Treatment Center, Inc. is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Alliance Treatment Center, Inc. is located at 121 West Avon Rd, Avon, CT 06001 with:

Mark Muradian as Executive Director

The maximum number of beds shall not exceed at any time:

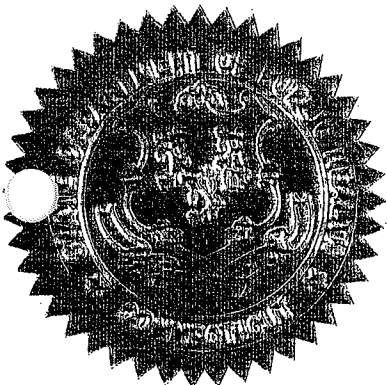
- 15 Intensive Treatment Beds
- 15 Residential Detoxification and Evaluation Beds

The service classification(s) and if applicable, the residential capacities are as follows:

- Residential Detoxification and Evaluation
- Intensive Treatment
- Day and Evening Treatment
- Outpatient Treatment
- Ambulatory Chemical Detoxification Treatment

This license expires **September 30, 2006** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2004. RENEWAL.



J. Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following:
(Please check all that apply)

This request is for Replacement Equipment.

The original equipment was authorized by the Commission/OHCA in Docket
Number: _____.

The cost of the equipment is not to exceed \$2,000,000.

The cost of the replacement equipment does not exceed the original cost
increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____,
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the
information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to
the best of my knowledge, and that _____ complies with the appropriate and
(Facility Name)
applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486
and/or 4-181 of the Connecticut General Statutes.

Signature

Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

COMMUNITY MENTAL HEALTH AFFILIATES, INC.

29 Russell Street
New Britain, CT 06052
Phone: 860-826-1358
Fax: (860) 229-6575

FAX TRANSMITTAL SHEET

To: Paola Fidicia Company:
Fax #: Phone #:
From: Mark Muradian
Date: 3-29-05 Total No. of Pages Including Cover: 2
Re:

___ Urgent ___ For Review ___ Please Comment ___ Please Reply ___ Please Recycle

Please: ___ DELIVER IMMEDIATELY
___ CONFIRM RECEIPT BY PHONE (1-860-826-1358)
___ HARD COPY TO FOLLOW IN MAIL

MESSAGE:

As requested, attached is a copy
of the affidavit. Original is being
mailed also.

Thank you .

RECEIVED
2005 MAR 29 PM 1:55
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

CONFIDENTIAL: This transmission is intended for the use of the individual(s) or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. Should the reader of this message not be the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify immediately by calling the sender at the above listed telephone number and/or return the original message to CMHA at the address listed. Thank you.

IF CLIENT DOCUMENT:

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT AND/OR PSYCHIATRIC RECORDS: THIS NOTICE ACCOMPANIES A DISCLOSURE OF INFORMATION CONCERNING A CLIENT IN ALCOHOL/DRUG ABUSE TREATMENT, MADE TO YOU WITH THE CONSENT OF SUCH CLIENT. THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.1 GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT. THE CONFIDENTIALITY OF THIS RECORD IS REQUIRED UNDER CHAPTER 899 OF THE CONNECTICUT GENERAL STATUTES. THIS MATERIAL SHALL NOT BE TRANSMITTED TO ANYONE WITHOUT WRITTEN AUTHORIZATION AS PROVIDED IN THE AFOREMENTIONED STATUTES.

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Page 6 of 7
9/13/02

AFFIDAVIT

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Applicant: Community Mental Health Affiliates, Inc.

Project Title: Alliance Treatment Center

I, Mark Muradian
(Name)

CEO
(Position – CEO or CFO)

of Community Mental Health
Affiliates, Inc.

being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Community Mental Health Affiliates, Inc. complies with the appropriate and (Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

March 29, 2005
Date

Subscribed and sworn to before me on March 29, 2005

Debora Naegelen

Notary Public Commissioner of Superior Court

My commission expires: October 31, 2007

DEBORA NAEGELEN
NOTARY PUBLIC

MY COMMISSION EXPIRES OCT. 31, 2007



COMMUNITY
MENTAL HEALTH
AFFILIATES, INC.

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2005 MAR 15 AM 11:45

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

March 9, 2005

Commissioner Christine Vogel
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Dear Commissioner Vogel:

Community Mental Health Associates, Inc. (CMHA) is in the process of submitting an application for State Bond Funds to the Department of Mental Health and Addiction Services (DMHAS) for \$1.3 million to renovate two floors at 33 Highland Street, New Britain. These funds will be utilized to house the Alliance Treatment Center (ATC) which is a "Facility for the Care or Treatment of Substance Abusive or Dependent Persons" currently located at 121 West Avon Road, Avon. ATC was designated to receive these funds under the 2004 legislative session bond appropriation process for DMHAS.

It is our intent to consolidate ATC into CMHA and operate the programs under CMHA once the facility is established at the Highland Street facility. Currently, Alliance Treatment Center is a subsidiary corporation of the Central Connecticut Health Alliance, which is CMHA's parent corporation. CMHA is the Local Mental Health Authority for DMHAS for the New Britain/Bristol area and seeks a Letter of Determination regarding the Certificate of Need process. Under CMHA, ATC will continue to primarily serve clients under DMHAS' SAGA program and access to recovery program. Additionally, ATC will continue to serve clients under the DSS Medicaid System.

In conjunction with this request for a Letter of Determination, we would like to activate the DMHAS review process for a waiver of a full Certificate of Need review. We are available to answer any questions by OHCA either in person or by phone at 826-1358. I am available to discuss this matter with you and/or your staff at your earliest convenience.

Thank you.

Sincerely,

Mark Muradian, DPA
Executive Director

Cc: Paul DiLeo, Commissioner Kirk, Larry Tanner

29 Russell Street • New Britain, Connecticut 06052 • (860) 826-1358 • FAX (860) 229-6575

www.cmhacc.org

